MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x Yes ( ) No
Requestor's Name and Address Edward Wolski, M.D. / Wol+Med 2436 I-35 South, Ste. 336 Denton TX 75205	MDR Tracking No.: M4-03-8885-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 47 Continental Casualty Co. c/o Wilson Grosenheider & J PO Box 1584 Austin TX 78767	Date of Injury: Employer's Name: Staff Leasing, Inc. Insurance Carrier's No.: 9000422872

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
9/16/02	**10/15/02**	**97545-WH, 97546-WH**	**$2,700.80**	**$563.20**

PART III: REQUESTOR'S POSITION SUMMARY

8/11/03: Requestor submitted to MDR the copies of medical documentation and stated in part: 1) "DOS 9/16/02 – 10/15/02: …the carrier failed to respond to our initial billing…(and)…request for reconsideration…2) DOS 10/7/02 – 10/9/02…denied "A" and "F"…failed to respond to our request for reconsideration…3) DOS 9/23/02 (CPT 97545-WH)…carrier processed this code for one (hour instead of two hours)…The carrier failed to respond…Our care has been reasonable, necessary, preauthorized (when applicable), and related to patient's compensable injury."

PART IV: RESPONDENT'S POSITION SUMMARY

8/21/03: Respondent from Wilson, Grosenheider & Jacobs, submitted a response stating in part: "Effective immediately…We have been retained by Continental Casualty Company to represent...The Statement of Disputed Issues: Provider seeks additional reimbursement for services and treatments provided to Jerry Bumpass (claimant) from 9/16/02 – 10/15/02…Provider is not entitled to reimbursement because Provider has been paid in full for all preauthorized work hardening. Provider sought and received preauthorization for two weeks of work hardening… (Exhibit 1)…was subsequently paid for eleven days… See EOB's and Payment Screen, Exhibit 2. All remaining DOS were not preauthorized, and no additional reimbursement is due…Provider owes a refund…for DOS 10/14/02 that was paid and not preauthorized…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- On 7/24/03, the Requestor submitted form TWCC-60 to MDR requesting reimbursement for treatment/services rendered from 9/16/02 through 10/15/02.

- To make the dispute complete, the Respondent provided timely copies of EOB's and TWCC-62's according to the Rule 133.307 (e)(2)(b) for DOS from 9/16/02 through 10/15/02.

- The preauthorization acknowledgement dated 9/16/02, stated: "NEGOTIATED APPROVAL NOTIFICATION: Approved Procedure: Work Hardening @ 5XWKX2WKS (total of 10 days). The DOS requested were 9/13/02 – 9/30/02. The Requestor submitted another preauthorization certification but it was for DOS outside the DOS in this dispute, therefore not applicable.

- The "Table of Disputed Services" from the Requestor indicated that $0.00 was received. Additional information received from the Requestor indicated the work hardening treatment/services began on 9/16/02 and they were not CARF accredited at that time.

- In review of the EOB's and the Respondent's 'payment computer screen print-out,' the following DOS were reimbursed according to the MFG/MGR (II)(C) & (E):
  9/18/02, 9/19/02, 9/20/02, 9/23/02 (except 2nd hour), 9/24/02, 9/26/02, 9/27/02 and 9/28/02.
  (A total of eight days show paid for the work hardening charges (except for 2nd hour on 9/23/02). Therefore, these DOS are no longer in dispute and will not be mentioned further in this Finding and Decision.

- With the above stated facts, the remaining DOS on the "Table of Disputed Services" that were within the preauthorized DOS were denied incorrectly with 'A-lack of preauthorization' and 'M-no MAR.' Therefore, reimbursement is recommended for DOS 9/16/02, 9/17/02 and the one hour remaining on 9/23/02.

DOS:	9/16/02 – 97545-WH = 2 units @ $51.20	= $102.40
	- 97546-WH = 3 units @ $51.20	= $153.60
DOS:	9/17/02 - 97545-WH = 2 units @ $51.20	= $102.40
	- 97546-WH = 3 units @ $51.20	= $153.60
DOS:	9/23/02 - 97545-WH = 1 unit @ $51.20	= $51.20
	TOTAL DUE:	**$563.20**

- The remaining DOS (10/7/02, 10/8/02, 10/9/02, and 10/15/02) on the "Table of Disputed Services" did not have convincing evidence that these DOS were certified with preauthorization, therefore additional reimbursement can not be recommended.

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $563.20. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Or

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to (additional) reimbursement.

Authorized Signature	Name	6 / 16 / 05 Date of Order

PART V: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, PO Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____